DATE: _____

CLINICAL AREA: _____

How' YOU Doin' in 2003?

Medical Records
And
Consents

June 23, 2003

Instructions:

- ❑ Test your knowledge by asking yourself and at least 5 of your colleagues the following questions.
- ❑ Indicate in the boxes whether you **answered the question correctly (Y)** or **were not able to answer the question (N).** Your manager or supervisor will be able to provide you with the correct answers.
- ❑ Give yourself and your colleagues a pat on the back for a job well done!!! Then, **send the results to Ginnie Daine by Monday, June 30th, 2003 (Room 10/7D55).**
- ❑ Got questions and you and your staff want to discuss a topic, simply check the box to the left of the topic.

Critical Issue	1	2	3	4	5	6
1. What consent documents should be in the medical record at the time of an outpatient visit?						
2. Who shares responsibility for verifying the Primary Physician entered in MIS?						
3. Are patients allowed to transport their medical record from one patient encounter area to another?						
4. Describe the steps you take prior to faxing patient-specific medical information.						
5. What type of documentation is required for a new outpatient?						
6. What type of documentation is required for a follow-up outpatient visit?						
7. Do I file documentation from an outpatient encounter in the medical record?						
8. How long can a patient's record remain on the clinic following an appointment?						
9. Must a patient sign a protocol consent for screening?						
10. Where do you send a patient's Authorization for Release of Medical Information NIH-527 (11-99)?						
11. What patient information can you release without the patient's prior written authorization?						
12. When are diagnostic reports available for review?						
13. Is it acceptable to place a patient identification label on the first and last pages of the protocol consent?						
14. How are EKG strips to be posted in the medical record?						
15. Where can I find a list of a patient's diagnoses and procedures?						

How' YOU Doin' in 2003?

The Answer Sheet☺

Medical Records and Consents

June 23, 2003

1. What consent documents should be in the medical record at the time of an outpatient visit?
   - The medical record should always include the original, signed and dated protocol consent document. Any operative or procedure consent should also be included prior to any invasive procedure being performed.
2. Who shares responsibility for verifying that the NIH/CC primary physician is entered in MIS?
   - The physician, nursing staff, and outpatient clerk should all be active in entering current information in MIS about the identity of the primary physician.
3. Are patients allowed to transport their medical record from one patient encounter area to another?
   - Yes. The medical record must be transported in the blue zippered bags provided to prevent contents from being lost. It was recently decided that the plastic ties are no longer needed.
4. Describe the steps you take prior to faxing patient-specific medical information.
   - Per Medical Executive Committee policy, all patient-identifiable, confidential medical record information transmitted by fax can be done ONLY with the patient's written consent or, in an emergency when a delay in communication might jeopardize the health of the patient. This policy is written in accordance with the Privacy Act.
   - Here are the steps you would take:
     1. Written patient consent must be obtained using the "Authorization for the Release of Medical Information (NIH-527). This should be available in every patient care area.
     2. The Medical Facsimile Cover Sheet (NIH 2781) must be used. A copy of the approved fax cover sheet is available from:
     3. Online from the CC's Home Page/Staff . . . http://www.cc.nih.gov/MRD/html_pages/NIH-2781_(2=01).pdf
     4. Medicolegal Section, Building 10, Room 1N216 (6-2292)
     5. Upon completion of the transmission, the completed fax cover sheet must be forwarded to the Medicolegal Section for inclusion in the patient's medical record. This serves as documentation of the transmission and that information was released properly.
   - Review this policy for additional information: M98-1 Facsimile Transmission of Individually-Identifiable, Confidential Medical Record Information Maintained under the Privacy Act (http://push.cc.nih.gov/policies/PDF/M98-1.pdf).
5. What type of documentation is required for a new outpatient?
   - The responsible primary physician/designee must type on an approved "First Registration Form" or dictate a "First Registration Report" for each new outpatient and include the date of visit, H&P, significant findings, clinical diagnoses, plan of care, dates of operations or procedures performed, instructions to the patient/family, and disposition.
6. What type of documentation is required for a follow-up outpatient visit?
   - Every episode of care must be documented in the medical record. A note must be legibly written or dictated within 24 hours of each outpatient encounter by a physician and/or other health care professional. Content is determined by the responsibilities of each practitioner and must be adequate to document the course of treatment, results, and promote continuity of care.
7. Do I file documentation from an outpatient encounter in the medical record?
   - No. Material accumulated from an outpatient encounter should be placed in the blue plastic envelope on the medical record return cart present in the outpatient clinic area. The material will be forwarded to the MRD for filing in the medical record.
   - Loose material is filed in medical records within 48 hours of receipt in the Record Management Section (10/1N211).

8. How long can a patient's record remain in the clinic following an appointment?
   - The medical record must be returned at the end of the day. In the outpatient clinic, medical records should be placed on the MR cart for pick-up at the end of the day.
   - The Medical Record Department is open Monday – Friday 7 am to 6 pm. After hours and weekends, requests for medical records for urgent patient care needs are routed to the Admissions staff

9. Must a patient sign protocol consent for screening?
   - Yes. Each person participating in research activities at the CC, or their legally authorized representative, must grant informed consent prior to beginning study participation. This includes granting consent to be screened for protocol eligibility.

10. Where do you send a patient's Authorization for Release of Medical Information NIH-527 (11-99)?
   - Send the signed "Authorization" to the Medicolegal Section of the Medical Record Department (10/1N216).
   - The patient must indicate on the "Authorization" the address to where their medical information will be sent. If the patient has authorized that their medical information be sent to their home address, the patient's home address must be included on the "Authorization" form. The MIS is not a reliable source of patient addresses for mailing confidential medical information.
   - If Medicolegal receives an "Authorization" form without the mailing address provided by the patient, the request cannot be processed. If it can be determined from where the request originated, Medicolegal Section will attempt to contact the Patient Care Unit/area to resolve the missing information.

11. What patient information can you release without the patient's prior written authorization?
   - Verification of an individual as a current inpatient.
   - The general condition of the patient (good, fair, stable, serious, or critical) with the permission of the patient's attending physician.
   - In emergency situations where the continued health of a patient is at stake, medical record information may be released. The information released should be limited to that required to resolve the patient emergency. The release of information may be by phone or fax. All such requests should be referred to the Medical Record Department whenever possible. However in cases where referral is not possible (e.g., Medical Records is closed), the information requested can be released quickly under the following conditions:
     1. Prior to releasing any information, the requestor MUST be called back to verify their identity and authenticity.
     2. The circumstances of the release must be documented in the patient's record.
     3. The Medical Record Department notified of the release by contacting the Medicolegal Section on 6-3332. Leave a message if you cannot reach them during normal business hours.

12. When are diagnostic reports available for review?
   - Preliminary reports are available in the MIS immediately following transcription. Once verified by the author, final reports print from the MIS on nursing units for inpatients and in the MRD for outpatients.

13. Is it acceptable to place a patient identification label on the first and last pages of the protocol consent?
   - No. Each page of a document in the medical record must have the patient's full name and medical record number in the lower left corner.

14. How are EKG strips to be posted in the medical record?
   - EKG strips and other tracings are taped to either a Progress Notes or a Nursing Note.

15. Where can I find a list of a patient's diagnoses and procedures?
   - In the medical record . . . in Section I, under the Unit Index divider.